

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/20/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445319	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/16/2010
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NAME OF PROVIDER OR SUPPLIER

WILLOWS AT WINCHESTER CARE & REHABILITATION CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE

32 MEMORIAL DRIVE

WINCHESTER, TN 37398

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS	F 000		
F 250 SS=D	<p>On December 14 - 16, 2010 the annual Recertification survey and investigation of complaint #27068 was completed. No deficiencies were cited related to the complaint.</p> <p>483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE</p> <p>The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.</p> <p>This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to provide services based on the physician's recommendation regarding a HOSPICE referral for one (#1) of twenty-one residents reviewed.</p> <p>The findings included:</p> <p>Resident #1 was admitted on July 30, 2010, with diagnoses including Anemia, Diabetes Mellitus, Chronic Kidney Disease, Congestive Heart Failure, and Left Above the Knee Amputation.</p> <p>Medical record review of the Minimum Data Set dated September 20, 2010, revealed the resident had short/long term memory deficits, required total assistance from staff with transfers, dressing, personal hygiene, and bathing.</p> <p>Review of the physician's progress note/evaluation dated November 23, 2010, revealed, "...Plan: 1. The origin of the anemia is</p>	<p>"This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Willows at Winchester Care & Rehabilitation Center does not admit that the deficiency listed on this form exist, nor does the Center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency."</p> <p>F250</p> <p>1. The Director of Nursing called the physician for resident #1 to verify hospice referral on 12/16/10 and physician orders were obtained based on the resident's current status.</p> <p>2. The Director of Nursing and Staff Development Coordinator audited physician progress notes on 12/20/10 to identify other physician</p>		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Human Manager

Administrator

12/30/10

A deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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NAME OF PROVIDER OR SUPPLIER WILLOWS AT WINCHESTER CARE & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 32 MEMORIAL DRIVE WINCHESTER, TN 37398		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 250	Continued From page 1 multifactorial. It is from renal insufficiency, chronic illness, chronic infection, and poor nutrition...(gender) would be very HOSPICE appropriate at this point if the family agrees." Review of the Social Services documentation from September 22, 2010 through December 15, 2010, revealed no documentation the physician's referral had been addressed. Observation on December 14, 2010, at 5:10 p.m., revealed the resident in bed, lying on an air mattress with the face partially covered with the sheet. Continued observation and interview with the resident at this time revealed the resident was alert, oriented, and carried on conversation with ease. Interview with the Social Worker on December 16, 2010, at 8:10 a.m., in the Social Services office confirmed no knowledge of the physician's referral and no contact with the family had been made in regards to HOSPICE. Interview with the Director of Nursing on December 16, 2010, at 8:20 a.m., at the nurse's station confirmed the physician's plan to refer the resident for HOSPICE services had not been addressed.	F 250	recommendations. No concerns were identified. 3. The Director of Nursing Services and the Staff Development Coordinator provided re-education to the Social Services Director, licensed nurses and Health Information Manager on 12/21/10 on identifying and following physician recommendations. 4. The Director of Nursing, Assistant Director of Nursing or Staff Development Coordinator will audit the physician progress notes weekly times four (4) weeks then monthly times two (2) months to ensure that any recommendations have been addressed. Results will be discussed at the Performance Improvement (PI) Committee for further recommendations and/or suggestions and follow up as needed. The PI committee consists of Administrator, Director of Nursing Services, and Assistant Director of Nursing Services, Maintenance Director, Medical Director, Business Office Manager, Social Services Director, Activities Director, Admissions/Marketing Director, Environmental Services Director, Staff Development, Nutritional		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation,	F 281			

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F 250	Continued From page 1 multifactorial. It is from renal insufficiency, chronic illness, chronic infection, and poor nutrition...(gender) would be very HOSPICE appropriate at this point if the family agrees." Review of the Social Services documentation from September 22, 2010 through December 15, 2010, revealed no documentation the physician's referral had been addressed. Observation on December 14, 2010, at 5:10 p.m., revealed the resident in bed, lying on an air mattress with the face partially covered with the sheet. Continued observation and interview with the resident at this time revealed the resident was alert, oriented, and carried on conversation with ease. Interview with the Social Worker on December 16, 2010, at 8:10 a.m., in the Social Services office confirmed no knowledge of the physician's referral and no contact with the family had been made in regards to HOSPICE. Interview with the Director of Nursing on December 16, 2010, at 8:20 a.m., at the nurse's station confirmed the physician's plan to refer the resident for HOSPICE services had not been addressed.	F 250	Services Director, Health Information Manager, Therapy Program Manager, Clinical Case Manager, and MDS Coordinator. All members are invited to attend monthly PI Committee meetings. Compliance Date 1/10/11		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation,	F 281	F281 1. Resident #1 received her 4pm dose of eye drops on 12/15/10. The physician was notified of the findings by the Director of Nursing on 12/15/10. Resident #1 did not experience any complications from these findings. 2. The Director of Nursing and Staff Development Coordinator conducted audits on 12/17/10 of resident's physician orders and medication availability and concerns were not identified. 3. The Director of Nursing, Staff Development Coordinator and Assistant Director of Nursing will provide re-education to licensed nursing personnel regarding the need		

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F 281	Continued From page 2 and interview, the facility failed to follow the physician's order for one (#21) of twenty-one residents reviewed. The findings included: Resident # 1 was admitted to the facility on November 17, 2009, with diagnoses including Congestive Heart Failure, Muscular Wasting and Disuse Atrophy, Atrial Fibrillation, and Psychosis. Medical record review of the Active Orders from 12/1/2010 to 12/31/2010 signed by the physician December 1, 2010, revealed "...(brand name) Solution Ophthalmic - TID (three times a day) 0800 (8:00 am) 1200 (12:00 pm) 1600 (4:00 pm) dry eyes..." Observation during the B-Wing medication pass on December 15, 2010, at 7:40 a.m., revealed the Licensed Practical Nurse (LPN) did not have the ordered eye drops on the medication cart to administer. Interview on December 15, 2010, at 7:45 a.m., with the B-Wing LPN in the medication room, confirmed the eye drops were not available to administer to the resident as ordered by the physician. Interview with the B-Wing LPN in the A-Wing hallway on December 15, 2010, at 2:12 p.m., confirmed the resident had not received the 8:00 a.m., and the 12:00 p.m., eye drops as ordered by the physician.	F 281	to ensure medication availability and following physician orders by 1/7/10. 4. The Director of Nursing, Assistant Director of Nursing or Staff Development Coordinator will complete an audit of medication availability and following physician orders weekly times four (4) weeks then monthly times two (2) months. Results will be discussed at the Performance Improvement (PI) Committee for further recommendations and/or suggestions and follow up as needed. The PI committee consists of Administrator, Director of Nursing Services, and Assistant Director of Nursing Services, Maintenance Director, Medical Director, Business Office Manager, Social Services Director, Activities Director, Admissions/Marketing Director, Environmental Services Director, Staff Development, Nutritional Services Director, Health Information Manager, Therapy Program Manager, Clinical Case Manager, and MDS Coordinator. All members are invited to attend monthly PI Committee meetings. Compliance Date 1/10/11		
F 283 SS=D	483.20(l)(1)&(2) ANTICIPATE DISCHARGE; RECAP STAY/FINAL STATUS When the facility anticipates discharge a resident must have a discharge summary that includes a recapitulation of the resident's stay; and a final	F 283			

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F 283	<p>Continued From page 3</p> <p>summary of the resident's status to include items in paragraph (b)(2) of this section, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or legal representative.</p> <p>This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, the facility failed to ensure discharge summaries were complete to reflect a summary of the resident's stay, for three (#14, #15, #17) of twenty-one residents reviewed.</p> <p>The findings included:</p> <p>Medical record review revealed resident #14 was admitted to the facility on May 7, 2010, with diagnoses including Hypertension, Osteoporosis, Depression, Asthma, and MRSA (Methicillin Resistant Staphylococcus Aureus) in right hip wound. Continued medical record review revealed the resident was discharged on June 14, 2010, to an acute care hospital for wound care. Further review of the medical record and the discharge summary revealed the sections on Final Diagnosis, Brief History, Pertinent Physician and Laboratory Findings, and Condition on Discharge were not completed.</p> <p>Medical record review revealed resident #15 was admitted to the facility on March 8, 2008, with diagnoses including Closed Head Injury, Hepatitis C, Hemiplegia, Hypertension, and Seizures. Continued medical record review revealed the resident was discharged on June 5, 2010, to a facility with a Behavioral Unit. Further review of the medical record and discharge summary</p>	F 283	<p>F283</p> <ol style="list-style-type: none"> 1. Resident # 14 was discharged from the facility on June 14, 2010. Resident # 15 was discharge from the facility on June 5, 2010. Resident # 17 was discharged from the facility on November 11, 2010. 2. The Director of Nursing, Assistant Director of Nursing and Staff Development Coordinator will review the last 5 discharges from the facility by 12/31/10 and ensure the Recapitulation of Stay is complete. 3. The Director of Nursing will re-educate the Interdisciplinary Team on completion of the Recapitulation of Stay form for discharged residents by 1/7/10. 4. The Director of Nursing, Assistant Director of Nursing, Staff Development Coordinator or Health Information Manager will audit the Recapitulation of Stay form for completion weekly times four (4) weeks then monthly times two (2) 		

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F 283	Continued From page 4 revealed the sections on Final Diagnosis, Brief History, Pertinent Physical and Laboratory Findings, and Condition on Discharge were not completed. Medical record review revealed resident #17 was admitted to the facility on October 25, 2010, with diagnoses including Chronic Obstructive Pulmonary Disease, Hypertension, Rheumatoid Arthritis, and Degenerative Joint Disease. Continued medical record review revealed the resident was discharged on November 11, 2010, to an acute care hospital. Further review of the medical record and discharge summary revealed the sections on Final Diagnosis, Brief History, Pertinent Physical and Laboratory Findings, and Condition on Discharge were not completed. Interview with the Licensed Practical Nurse on duty on C-wing on December 15, 2010, at 3:40 p.m., in the nurses' station, confirmed the discharge summaries were not complete for the three residents.	F 283	months. Results will be discussed at the Performance Improvement (PI) Committee for further recommendations and/or suggestions and follow up as needed. The PI committee consists of Administrator, Director of Nursing Services, and Assistant Director of Nursing Services, Maintenance Director, Medical Director, Business Office Manager, Social Services Director, Activities Director, Admissions/Marketing Director, Environmental Services Director, Staff Development, Nutritional Services Director, Health Information Manager, Therapy Program Manager, Clinical Case Manager, and MDS Coordinator. All members are invited to attend monthly PI Committee meetings.	
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to ensure a safety	F 323	Compliance Date 1/10/11 F323 1. On 12/14/10 the Assistant Director of Nursing replaced the pressure pad alarm on the bed for resident #4. The Assistant Director of Nursing secured	

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F 323	<p>Continued From page 5</p> <p>device was in place for one (#4) of twenty-one residents reviewed, failed to ensure an oxygen tank was secured, and failed to ensure doors that lead to hazardous areas were locked.</p> <p>The findings included:</p> <p>Resident #4 was admitted to the facility on June 4, 2008, with diagnoses including Dementia, Hypertension, Osteoporosis, and Abnormality of Gait. Continued record review revealed the resident had a history of falls. Review of the Minimum Data Set dated September 14, 2010, revealed the resident had short/long term memory deficits, cognitive impairment, and required extensive assist with transfers.</p> <p>Review of the physician's recapitulation orders dated December 1, 2010 to December 31, 2010, revealed, an order for "...Pressure sensitive bed alarm nurse to check Q (every) shift..."</p> <p>Observation and interview with the Licensed Practical Nurse for A-Wing on December 14, 2010, at 7:30 p.m., in the resident's room, confirmed the resident was in bed, and the pressure pad alarm was not in place.</p> <p>Observation during the initial tour in Room 109 on December 14, 2010, at 5:25 p.m., revealed an unsecured oxygen tank laying in the geri-chair in the resident's room. Continued observation of the A-Wing at this time revealed an unlocked door across the hall from resident Room 107. Observation revealed the door opened into the back of large equipment and electrical connections.</p> <p>Interview with the Maintenance Supervisor on</p>	F 323	<p>the oxygen tank in room 109 on 12/14/10. The Maintenance Director locked the laundry access door on 12/14/10.</p> <p>2. On 12/14/2010 the Director of Nursing, Assistant Director of Nursing and the Staff Development Coordinator audited residents with an order for pressure sensitive alarms to ensure the devices were in place and oxygen tanks were secured. The doors that require to be locked were checked by the Maintenance Director on 12/14/10.</p> <p>3. The Director of Nursing, Assistant Director of Nursing and Staff Development Coordinator will provide re-education to staff on resident environment remaining free of accident hazards, supervision and assistance devices to prevent accidents by 1/7/10.</p> <p>4. The Director of Nursing, Assistant Director of Nursing or Staff Development Coordinator will complete audits to ensure pressure alarm devices are in place and oxygen tanks are secured. The Maintenance Director will complete audits to ensure doors that need to be locked for safety are locked. The audits will be</p>		

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F 323	Continued From page 6 December 14, 2010, at 5:25 p.m., confirmed the oxygen tank had not been secured properly. Continued interview revealed the unidentified, unlocked door opened into the laundry room, and should have been locked to prevent unauthorized access. Continued interview confirmed the rear door to the laundry was used for accessing the back of the dryers for cleaning and maintenance purposes only.	F 323	completed weekly times four (4) weeks then monthly times (2) months. Results will be discussed at the Performance Improvement (PI) Committee for further recommendations and/or suggestions and follow up as needed. The PI committee consists of Administrator, Director of Nursing Services, and Assistant Director of Nursing Services, Maintenance Director, Medical Director, Business Office Manager, Social Services Director, Activities Director, Admissions/Marketing Director, Environmental Services Director, Staff Development, Nutritional Services Director, Health Information Manager, Therapy Program Manager, Clinical Case Manager, and MDS Coordinator. All members are invited to attend monthly PI Committee meetings.		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation during the initial tour of the facility, the facility failed to ensure food for the residents was stored in a safe manner. The findings included: Observation during the initial tour on December 14, 2010, at 5:30 p.m., of the refrigerator in the Ice Room on C-wing, revealed two plastic containers of pureed food labeled with the name of a resident on the C-wing, and there was no date on the containers to indicate when they were placed in the refrigerator.	F 371	Compliance Date 1/10/11 F371 1. The Nutritional Services Director and Registered Dietician removed the pureed food, cheese slices, Mountain Dew and sandwich that were not		

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F 371	Continued From page 7 Continued observation of the Ice Room refrigerator revealed several slices of cheese in a plastic bag, labeled with the name of a resident who had been discharged, but no date on the bag to indicate when it was placed in the refrigerator. Further observation of the Ice Room refrigerator revealed a bottle of Diet Mountain Dew, partly consumed, with no label or date to indicate when it was placed in the refrigerator. Continued observation of the Ice Room revealed a sandwich in a pharmacy bag labeled with the name of a resident on the A-wing, but no date on the bag to indicate when it was placed in the refrigerator. Interview with the Licensed Practical Nurse responsible for C-wing on December 14, 2010, at 5:45 p.m., in the Ice Room, confirmed the containers of pureed food, slices of cheese, sandwich, and Mountain Dew were not dated to indicate when they were placed in the refrigerator.	F 371	labeled and dated from the refrigerator in the C-wing ice room on 12/14/10. 2. The Nutritional Services Director conducted a review of the refrigerators to identify any other items that were undated and removed them on 12/14/10. 3. The Staff Development Coordinator or Nutritional Services Director will re-educate staff on labeling and dating food and liquids placed in refrigerators by 1/7/11. 4. The Housekeeping Supervisor or housekeeping staff will audit the refrigerators daily to ensure that food items are labeled and dated. The daily audit sheets will be provided to the PI committee every month times three (3) months. Results will be discussed at the Performance Improvement (PI) Committee for further recommendations and/or suggestions and follow up as needed. The PI committee consists of Administrator, Director of Nursing Services, and Assistant Director of Nursing Services, Maintenance Director, Medical Director, Business Office Manager, Social Services Director, Activities Director, Admissions/Marketing Director,		
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and	F 441			

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F 441	<p>Continued From page 8</p> <p>(3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure a sanitary environment to prevent the development and transmission of disease for one (#10) using oxygen and two random residents with nebulizers of twenty-one residents reviewed and for three of three medication carts.</p> <p>The findings included: Observation on December 14, 2010 at 5:23 p.m., revealed resident #10 not in the room and the oxygen concentrator was working. Further</p>	F 441	<p>Environmental Services Director, Staff Development, Nutritional Services Director, Health Information Manager, Therapy Program Manager, Clinical Case Manager, and MDS Coordinator. All members are invited to attend monthly PI Committee meetings.</p> <p>Compliance Date 1/10/11</p> <p>F441</p> <p>1. Resident #10's oxygen tubing was replaced and put in a bag on 12/14/10 by the Director of Nursing. On 12/14/10 the Director of Nursing, Assistant Director of Nursing and Staff Development Coordinator changed the nebulizer, mask and mouth piece for identified residents on B and C wing. The Director of Nursing replaced the blood pressure cuffs and stethoscopes found lying across the biohazard sharps container before 1/7/10.</p> <p>2. The Director of Nursing, Assistant Director of Nursing and Staff Development Coordinator completed a review of residents with oxygen and nebulizers to ensure they were in bag</p>		

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F 441	<p>Continued From page 9</p> <p>observation revealed the oxygen tubing lying across the width of the bed with the nasal cannula hanging off the side of the bed just above the floor.</p> <p>Interview with the B Wing Licensed Practical Nurse, responsible for the care of the resident, on December 14, 2010 at 5:24 p.m., in the resident's room, confirmed the tubing and nasal cannula were to be stored in a sealable bag when not in use in order to prevent infection.</p> <p>Observation on December 14, 2010 at 5:45 p.m., in a random resident's room on B Wing, revealed an uncovered nebulizer machine on the bedside table. Further observation revealed the nebulizer compartment lid propped open by the tubing and mask stored in the compartment. Further observation revealed the mask and nebulizer were not covered.</p> <p>Interview with the B Wing Licensed Practical Nurse, responsible for the care of the resident, on December 14, 2010 at 5:52 p.m., confirmed the nebulizer and the mask were to be stored in a sealable bag when not in use in order to prevent infection.</p> <p>Observation during the initial tour on December 14, 2010, at 4:55 p.m., in a random resident's room on C-wing, revealed a nebulizer with mouth piece lying uncovered on the compartment.</p> <p>Interview with the Licensed Practical Nurse responsible for C-wing, confirmed the nebulizer was uncovered and was to be contained in a plastic bag with drawstring when not in use.</p> <p>Observation during the medication pass on</p>	F 441	<p>when not in use on 12/17/10. This review also included blood pressure cuffs and stethoscopes to ensure they were not on top of the biohazard sharps containers.</p> <p>3. The Director of Nursing, Assistant Director of Nursing or Staff Development Coordinator will re-educate staff on the storing of oxygen tubing, nebulizer mask and mouth piece in bag when not in use and not placing blood pressure cuffs and stethoscopes on biohazard sharps containers by 1/7/11.</p> <p>4. The Director of Nursing, Assistant Director of Nursing or Staff Development Coordinator will complete infection control audits to include oxygen tubing, nebulizer mask and mouth piece in a bag when not in use and medication carts to ensure blood pressure cuffs and stethoscopes are not placed on top of biohazard sharps containers. The audits will be completed weekly times four (4) weeks then monthly times two (2) months. Results will be discussed at the Performance Improvement (PI) Committee for further recommendations and/or suggestions and follow up as needed. The PI committee consists of Administrator,</p>		

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F 441	Continued From page 10 December 15, 2010, at 7:40 a.m., revealed two stethoscopes and two blood pressure cuffs laying across the top of the biohazard sharps container on the side to the B-Wing medication cart. Observation of the A-Wing medication cart on December 15, 2010, at 8:15 a.m., revealed a blood pressure cuff laying across the top of the biohazard sharps container on the side of the medication cart. Observation of the C-Wing medication cart on December 16, 2010, at 9:00 a.m., revealed a blood pressure cuff laying across the top of the biohazard sharps container on the side of the medication cart. Interview with the Director of Nursing on December 16, 2010, at 11:30 a.m., at the nurse's station confirmed stethoscopes and blood pressure cuffs (clean items) should not be placed on the biohazard sharps container (dirty area.)	F 441	Director of Nursing Services, and Assistant Director of Nursing Services, Maintenance Director, Medical Director, Business Office Manager, Social Services Director, Activities Director, Admissions/Marketing Director, Environmental Services Director, Staff Development, Nutritional Services Director, Health Information Manager, Therapy Program Manager, Clinical Case Manager, and MDS Coordinator. All members are invited to attend monthly PI Committee meetings. Compliance Date 1/10/11		
F 514 SS-E	483.75(l)(1) RES RECORDS-COMplete/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.	F 514	1. Resident's # 2, # 5, # 7, and #12 will be re-assessed for pain and medical record updated to reflect current status by the Director of Nursing or Assistant Director of Nursing before 12/31/10. 2. The Director of Nursing, Assistant Director of Nursing and Staff Development Coordinator conducted a review of residents to ensure that pain has been re-assessed and that the		

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F 514	<p>Continued From page 11</p> <p>This REQUIREMENT is not met as evidenced by: Based on medical record review, facility policy review, Consultant Pharmacy Report review, and interview, the facility failed to maintain complete and accurate medical records for four (#2, #5, #7, #12) of twenty-one residents reviewed.</p> <p>The findings included:</p> <p>Resident #2 was admitted to the facility on June 8, 2010, with diagnoses including Chronic Pain, Spinal Cord Injury, and Multiple Pressure Ulcers to Lower Back, Knee, Ankle and Hip.</p> <p>Medical record review of the Minimum Data Set dated September 6, 2010 revealed the resident had no memory or cognitive deficit and had moderate pain.</p> <p>Medical record review of the physician Recapitulation orders for December 2010 revealed "...Hydrocodone-Acetaminophen 5-325 milligrams 1 tablet by mouth every 4 hours as needed (PRN) for pain..."</p> <p>Medical record review of the Medication Administration Record (MAR) for December 2010 revealed a total of seven administrations of the PRN Hydrocodone-Acetaminophen.</p> <p>Medical record review of the Controlled Drug Record dated December 2010 for the PRN Hydrocodone-Acetaminophen, revealed twenty-nine administrations.</p> <p>Medical record review of the Pain Management Flow Sheet for December 2010 revealed a total of</p>	F 514	<p>Medication Administration Record, Pain Management flow sheet and Controlled drug record reflects residents current status before 1/7/11.</p> <p>3. The licensed nurses will be re-educated on completing Medication Administration Records, Pain Management flow sheets and Controlled Drug records by the Director or Nursing or Staff Development Coordinator by 1/7/10.</p> <p>4. The Director of Nursing, Assistant Director of Nursing or Staff Development Coordinator will audit the Medication Administration Records, Pain Management flow sheets and Controlled Drug Record to ensure they match weekly times four (4) weeks then monthly times two (2). Results will be discussed at the Performance Improvement (PI) Committee for further recommendations and/or suggestions and follow up as needed. The PI committee consists of Administrator, Director of Nursing Services, and Assistant Director of Nursing Services, Maintenance Director, Medical Director, Business Office Manager, Social Services Director, Activities Director, Admissions/Marketing Director,</p>		

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F 514	<p>Continued From page 12</p> <p>two pain evaluations with the PRN Hydrocodone-Acetaminophen as an intervention.</p> <p>Review of the facility policy entitled "6.0 General Dose Preparation and Medication Administration, effective 12/01/07, revised 5/01/10," revealed "...Procedure:...5. During medication administration, Facility staff should take all measures required by Facility policy and Applicable Law, including, but not limited to the following:...5.5. Document the administration of controlled substances in accordance with Applicable Law;...6. After medication administration, Facility staff should take all measures required by Facility policy and Applicable Law, including, but not limited to the following:...6.1 Document necessary medication administration/treatment information (e.g., ...when medications are given,...PRN medications,...) on appropriate forms;..."</p> <p>Review of the facility Pain Management Program revealed "...PRN Pain Medication When analgesics are administered in response to an episode of pain, licensed nurses must document their evaluation, treatment, and effectiveness of the treatment on the PRN Pain Management Flow Sheet...The flow sheet requires documentation of the following information: 1. Pain evaluation and treatment Date and time, Pain rating, Non-pharmacological treatment provided, Location of pain, Medication dose..."</p> <p>Interview, with the Staff Coordinator on December 16, 2010 at 11:12 a.m., in the nursing station, confirmed the December 2010 MAR, Controlled Drug Record and Pain Management Flow Sheet did not match and the medical record was not complete or accurate.</p>	F 514	<p>Environmental Services Director, Staff Development, Nutritional Services Director, Health Information Manager, Therapy Program Manager, Clinical Case Manager, and MDS Coordinator. All members are invited to attend monthly PI Committee meetings.</p> <p>Compliance Date 1/10/11</p>		

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F 514	Continued From page 13 Resident #5 was admitted to the facility on September 11, 2010, and readmitted on December 10, 2010, with diagnoses including Stage IV Chronic Kidney Disease, Chronic Ischemic Heart Disease, Congestive Heart Failure, Peripheral Vascular Disease, Varicose Veins Lower Extremities with Ulceration and Inflammation, and Diabetes Mellitus. Medical record review of the Minimum Data Set dated September 21, 2010 revealed the resident had no cognitive or memory deficit and mild pain. Medical record review of the physician Recapitulation orders for November and December 2010 revealed "...Hydrocodone-Acetaminophen 5-325 milligram Tablet by mouth as needed (PRN): may have 2 tablets every (q) 6 hours PAIN..." Medical record review of the Medication Administration Record (MAR) for November 2010 revealed a total of twenty-two administrations of the PRN Hydrocodone-Acetaminophen. Review of the December 2010 MAR revealed a total of nine administrations of the PRN Hydrocodone-Acetaminophen. Medical record review of the Controlled Drug Record for November 2010 of the PRN Hydrocodone-Acetaminophen revealed a total of thirty administrations. Review of the December 2010 Controlled Drug Record revealed a total of fifteen administrations of the PRN Hydrocodone-Acetaminophen. Medical record review of the Pain Management	F 514			

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F 514	<p>Continued From page 14</p> <p>Flow Sheet for November 2010 revealed a total of six pain evaluations with the PRN Hydrocodone-Acetaminophen as the intervention.</p> <p>Interview, with the Administrator and Director of Nursing on December 15, 2010 at 4:35 p.m., at the nursing station, confirmed the PRN medication documentation on the MAR, Controlled Drug Record and Pain Management Flow Sheet did not match so that the medical record was not accurate or complete.</p> <p>Resident #7 was admitted to the facility on December 18, 2008, with diagnoses including Pathological Fracture of Humerus, Disorder of Bone and Cartilage, Late Effect Cerebrovascular Disease, Chronic Ischemic Heart Disease, Diabetes Mellitus, Malignant Neoplasm of Breast, and Osteoporosis.</p> <p>Medical record review of the Minimum Data Set dated October 21, 2010 revealed the resident had cognitive and memory deficit and moderate pain.</p> <p>Medical record review of the physician Recapitulation orders for November and December 2010 revealed "...Lortab 5 (Acetaminophen-Hydrocodone) 5-500 milligram tablet Enteral Tube-as needed (PRN): one every 6 hours as needed Pain ..."</p> <p>Medical record review of the Medication Administration Record (MAR) for November 2010 revealed a total of seventeen administrations of the PRN Hydrocodone-Acetaminophen. Review of the December 2010 MAR revealed a total of thirteen administrations of the PRN Hydrocodone-Acetaminophen.</p>	F 514			

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F 514	<p>Continued From page 15</p> <p>Medical record review of the Controlled Drug Record for November 2010 of the PRN Hydrocodone-Acetaminophen revealed a total of twenty-four administrations. Review of the December 2010 Controlled Drug Record revealed a total of seventeen administrations of the PRN Hydrocodone-Acetaminophen.</p> <p>Medical record review of the Pain Management Flow Sheet for November and December 2010 revealed a total of four pain evaluations each month with the intervention of the PRN Hydrocodone-Acetaminophen.</p> <p>Interview, with the Director of Nursing in the Assistant Director of Nursing office, on December 15, 2010 at 1:15 p.m., confirmed the PRN medication documentation on the MAR, Controlled Drug Record and Pain Management Flow Sheet did not match so that the medical record was not accurate or complete. Further interview revealed the nurses were to document on the MAR, Controlled Drug Record and the Pain Management Flow Sheet every time a PRN pain medication was administered and the facility failed to follow their policy.</p> <p>Medical record review revealed resident #12 was admitted to the facility on September 21, 2010, with diagnoses including End Stage Renal Disease, Diabetes Mellitus, Cerebrovascular Accident with Left Hemiparesis, Hypertension, Chronic Obstructive Pulmonary Disease, Right Above Knee Amputation, Gastroesophageal Reflux Disease, Peripheral Vascular Disease, Seizures, and Hemodialysis. Continued review of</p>	F 514			

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F 514	<p>Continued From page 16</p> <p>the medical record revealed a physician's order dated September 21, 2010, which stated "Lortab (Acetaminophen-Hydrocodone) 7.5/500 mg (milligrams) orally. May have 1 tab (tablet) Q6 hrs (every 6 hours) PRN (as needed).</p> <p>Review of the Controlled Drug Record for November 2010, revealed nurses signed out seventy-five doses of Lortab during the month of November.</p> <p>Review of the Medical Administration Record for November revealed nurses documented forty-one doses of Lortab administered during the month of November.</p> <p>Review of the Pain Management Flow Sheet revealed nurses documented five doses of Lortab administered during the month of November. Continued review of the Pain Management Flow Sheet revealed only on one occasion, November 17, 2010, at 5:30 p.m., was the effectiveness of treatment documented.</p> <p>Interview with the Director of Nursing on December 16, 2010, at 9:30 a.m., in the conference room, confirmed the nurses failed to document thirty-four doses of Lortab on the Medication Administration Record and seventy doses of Lortab on the Pain Management Flow Sheet.</p> <p>Review of the Consultant Pharmacy Report dated November 22, 2010, revealed a comment of "MAR (Medication Administration Record) omissions noted."</p> <p>Review of the controlled substance sheets and actual count of medications revealed all</p>	F 514			

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F 514	Continued From page 17 medications were accounted for.	F 514			